Promoting adolescent sexual and reproductive health through schools in low income countries: an information brief

Department of Child and Adolescent Health and Development

Geneva, 2008

World Health Organization

WHO/FCH/CAH/ADH/09.03

World Health Organization

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ABBREVIATIONS

CDC	Centers for Disease Control and Prevention
DASH	Division of Adolescent and School Health
EDC	Education Development Center
EDC/HHD	Education Development Center, Health and Human Development
EDUCAIDS	Global Initiative on Education and HIV/AIDS
EFAIDS	Education for AIDS
FAO	Food and Agriculture Organization of the United Nations
FRESH	Focusing Resources on Effective School Health
GSHS	global school-based student health survey
IATT	UNAIDS Inter-Agency Task Team (on Education)
RAAPP	rapid assessment and action planning process
SRH	sexual and reproductive health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

This information brief has been prepared to support World Health Organization (WHO) staff working at the international, regional and national levels to promote the uptake of adolescent SRH through schools in low-income countries. It is drafted by Meena Cabral de Mello, Adolescent Health and Development Team, WHO and integrates the review and valuable suggestions of team members including Venkatraman Chandra-Mouli, Jane Ferguson, Paul Bloem, Krishna Bose, and Garrett Mehl. It is also enriched by constructive inputs from Gauden Galea, Coordinator, Health Promotion Team, WHO; Carmen Aldridge, Education Development Center, WHO Collaborating Center, United States of America; and Helen Herrman, Professor of Psychiatry and Director of WHO Collaborating Centre in Mental Health, Australia. Valentina Baltag, Regional Advisor in Adolescent Health, WHO EURO; Ewa Nunes Sorenson, Advisor on Adolescent Health, Pan American Health Organization; Matilde Maddaleno, Regional Advisor in Adolescent Health, Pan American Health Organization; Neena Raina, Regional Advisor in Adolescent Health, WHO SEARO; and Rajesh Mehta, National Programme Officer, WHO India, provided invaluable guidance and comments for improving the content of this brief.

School-based sexual and reproductive health (SRH) education is one of the most important and widespread ways to help adolescents to recognize and avert risks and improve their reproductive health (1, 2). This information brief stresses the public health importance of adolescent SRH. It also outlines the contribution WHO staff at global, regional and country levels can make in assisting countries select effective strategies and actions to support school health education interventions. The brief is based on research and evaluated programmes that have been effective with adolescents in similar circumstances.

It is consistent with the approaches and frameworks that the partnership of agencies of school health utilizes for designing and implementing programmes and policies for adolescents. Box 1 contains definitions of some key terms used in the text.

Education itself can be a powerful vehicle for improving the health of adolescents. Higher levels of education are linked with economic growth and better health and reproductive health outcomes, including condom use, use of health services, knowledge about HIV and lower HIV seroprevalence. School-based HIV and SRH education can provide the practical knowledge and skills needed to reduce adolescents' vulnerability to reproductive health problems, including HIV infection. The knowledge and tools necessary to implement effective programmes are also available as a result of research and programme evaluations. Education has been shown to be a cost-effective means of addressing adolescent reproductive health and the HIV pandemic (7).

Box 1: DEFINITIONS

Sexual and reproductive health (SRH) education. Educational experiences that develop the capacity of adolescents to understand their sexuality in the context of biological, psychological, sociocultural and reproductive dimensions and to acquire skills in managing responsible decisions and actions with regard to SRH behaviour (3). SRH education aims to achieve a range of behavioural and health outcomes, including reduced sexual activity (including postponing age at first intercourse and promoting abstinence); reduced number of sexual partners; increased contraceptive use (especially use of condoms among adolescents who are sexually active, for dual protection); lower rates of child marriage; lower rates of early, unwanted pregnancy and resulting abortions; lower rates of infection with HIV and other sexually transmitted infections (STIs); and improved nutritional status (4). WHO recommends that SRH education be provided within the context of schools that promote health.

Health promotion. As stated in the Ottawa Charter (5), a process of enabling people to increase control over and to improve their health. This includes sexual and reproductive health.

Health-promoting school. Educational establishment where all members of the school community work together to provide students with integrated and positive experiences and structures that promote their health, including skills-based curricula in health, safe and healthy environments, appropriate health services and the involvement of families and the wider community in efforts to promote health (6).

1 WHY IS THE EDUCATIONAL SETTING IMPORTANT TO REACH ADOLESCENTS AND TO PROMOTE THEIR HEALTH?

In 2010, there will be more 10–19-year-olds on the planet than ever before – approximately 1.25 billion (*8*), 83% of whom will live in developing countries and will be most vulnerable to a range of reproductive health problems, including too-early pregnancy and childbearing; infertility; genital mutilation; unsafe abortion; STIs, including HIV; and gender-based violence, including sexual assault and rape. These problems are preventable and education is a key component of prevention. For example, the few countries that have successfully decreased national HIV prevalence have achieved those gains mostly by encouraging safer sexual behaviours in adolescents (*9*).

Schools are the primary institutions able to reach a majority of adolescents, while also having an impact at the community level. Four out of every five of the world's children aged between 10 and 15 are enrolled in secondary education (66% in 2005), which is now considered as part of compulsory education in most countries (*10, 11*). Schools have the infrastructure, the tools and the staff trained to teach. In many developing countries teachers assume an important role in the community, while also serving as role models to many adolescents (*12*). In addition, schools may often be the only place where adolescents can obtain accurate information on reproductive health. By providing reproductive health programmes early, schools encourage the formation of healthy sexual attitudes and practices. This is easier than changing well-established unhealthy habits later. Thus schools can promote healthy messages and establish helpful norms about SRH (*13*). Schools can also help create health equity: school health programmes can ensure that health promotion and care are accessed by poor and disadvantaged adolescents, especially girls, who would not otherwise have access to health information and services (*12*).

Many of the elements needed to build school-based programmes already exist. Some countries have ongoing school health programmes that can be expanded to include reproductive health (*14*). Besides providing education, schools can also provide basic services and counselling, or refer students to local adolescent-friendly health or counselling services when appropriate.

2 WHAT EVIDENCE IS THERE TO SHOW THAT ACTIONS IN EDUCATIONAL SETTINGS CAN PROMOTE THE SRH OF ADOLESCENTS?

The 2007 *Lancet* article on global perspectives on the sexual and reproductive health of adolescents (*15*) recommends that public health officials and policy-makers seriously consider curriculum-based programmes as an important component of efforts to achieve regional and national goals for preventing STIs, including HIV, and early pregnancy in adolescents. This recommendation is based on the findings of a major review of the effect of 85 evaluated school-based sex education programmes in developed and developing countries. The findings show that in about two thirds (65%) of the studies reviewed, school health education interventions were effective in creating a significant positive effect on one or more of the five reproductive health behaviours evaluated; only 7% of the studies found a significant negative effect; and a third (33%) of the programmes had a positive effect on two or more outcomes. The behaviours evaluated were sexual initiation, frequency of sexual intercourse, number of sexual partners, condom use and contraceptive use. The programmes were successful in all types of settings and countries (developing and developed), among males and females, for different age groups and among varying income levels. Also, many programmes had positive effects on the factors that determine sexual risk behaviours, including knowledge about STIs and pregnancy, awareness of risk, values and attitudes toward sexual topics, self-efficacy (negotiating condom use or refusing unwanted sex) and intentions to abstain or restrict the number of sexual partners (*15–17*).

More recently, the conclusions of a focused systematic review of school-based SRH education interventions in sub-Saharan Africa show that the most significant changes occur in knowledge and attitudes regarding HIV and other STIs (*18*). The next most significant changes are in outcomes relating to future intentions, followed by changes in actual sexual risk behaviour. Behavioural change in relation to abstinence was easier to effect among baseline virgins, while condom use was the more practicable sexual risk protective behaviour for adolescents who were already sexually active before the school health intervention.

Evaluations of school health interventions have shown that to be effective specific features must be present in education and information programmes. The following features have proved to be critical for effective education and information programmes:

- **Provide evidence and reassurance to policy-makers, parents, teachers and school officials of the beneficial effects of SRH education programmes.**

  Lessons learnt from a series of major reviews of research and programme data indicate that providing students in developing and developed countries with sex information, skills and services will not encourage earlier initiation of sex. Much evidence indicates that well-guided skill-based programmes are likely to promote abstinence and help adolescents to delay first sex, and tend to reduce the frequency of sex and number of sexual partners, thereby providing a definitive response to those who argue that reproductive health programmes for children may encourage sexual initiation or promiscuity (*2, 13, 19–21*).

- **Implement SRH education programmes that are curriculum based and led by adults.**

  After comparing various curriculum-based and non-curriculum-based intervention programmes led by adults or by peers, a study of the effectiveness of sex education and HIV education interventions in schools in developing countries found that the most effective programmes were curriculum-based programmes led by adults, including teachers, health servers, social workers and community members, and recommended that they should be implemented more widely (*22*). Health education programmes, however, cannot be carried out solely by social workers, school nurses and school administrators, but require the hard work and collaboration of teachers. Teachers should receive sufficient support, time and training, including pre-service and in-service training and practice, and they must be supported by school authorities, policy-makers and the wider community (*23*).

- **Ensure skill-based intervention programmes**

  Such programmes will be aimed at helping adolescents develop the knowledge, attitudes, values and skills – including interpersonal skills, critical and creative thinking, decision-making, and self-awareness – needed to make sound health-related decisions. For example, to avoid early pregnancy a young woman may need decision-making skills ("What are my options?"), value clarification skills ("What is important to me?"), self-management skills ("How can I protect myself? How can I achieve my goals?") and interpersonal skills ("How do I resist pressure to have sex and communicate my decision to others?"). Ultimately, it is the interplay between these skills that produces powerful behavioural outcomes (*24*). **SRH education must also include information and skills about both abstinence and contraception** in order to be effective in delaying the onset of first sexual intercourse, reducing the frequency of sex and number of sexual partners and ensuring that adolescents protect themselves when they become sexually active (*13*, *19–21*). Findings indicate that the effects of curriculum-based programmes are quite robust with different types of adolescents, and across communities, countries and cultures throughout the world. Typically, effective sex education programmes reduced the amount of sexual risk taking by up to a third (*15*).

- **Incorporate the identified characteristics of successful SRH education programmes**

  Recent reviews of the impact of sex and HIV education programmes on the sexual behaviour of adolescents (25) and the prevention of HIV in adolescents in developing countries (*16*) have enabled identification of **17 common characteristics** that effective programmes share. Source: Kirby et al 2005 (*25*).

Box 2: CHARACTERISTICS OF EFFECTIVE SEX EDUCATION PROGRAMMES

Curriculum development

1. Involved people with different backgrounds in theory, research, and sex education.
2. Planned specified health goals and identified behaviours affecting those goals, risk and protective factors affecting those behaviours, and activities to address those factors.
3. Assessed relevant needs and assets of target group.
4. Designed activities consistent with community values and available resources (e.g. staff skills, staff time, space, supplies).
5. Pilot-tested curriculum activities.

Content of curriculum

1. Created safe social environment for youth participants.
2. Focused on at least one of three health goals: prevention of HIV, of other STIs, and/or of unintended pregnancy.
3. Focused narrowly on specific sexual behaviours that lead to these health goals (e.g. abstaining from sex, using condoms); gave clear messages about these behaviours; addressed how to avoid situations that might lead to these behaviours.
4. Targeted several psychosocial risk and protective factors affecting these behaviours (e.g. knowledge, perceived risks, attitudes, perceived norms, self-efficacy).
5. Included multiple activities to change each of the targeted risk and protective factors.
6. Used teaching methods that actively involved youth participants, and helped them to personalize the information.
7. Made use of activities appropriate to the young people's culture, developmental level, and previous sexual experience.
8. Addressed topics in a logical order.

Curriculum implementation

1. Selected educators with desired characteristics, and provided training in curriculum.
2. Secured at least minimum support from appropriate authorities (e.g. ministry of health, school district, community organization).
3. If needed, implemented activities to recruit youth and overcome barriers to their involvement in programme.
4. Implemented virtually all curriculum activities with fidelity.

These characteristics relate to the development, content and implementation of the curriculum. Based on these curricular characteristics and lessons learnt in implementing SRH curricula in different field contexts, Family Health International (FHI) has developed, and published in a manual, **24 standards** that can be applied to curriculum-based reproductive health and HIV education programmes (*26*). Programme designers, curriculum developers, educators, managers, evaluators and others can use the manual to assess the quality of existing programmes and guide the adaptation or development and implementation of a new curriculum. For example, the United Nations Children's Fund (UNICEF) is using the standards to guide programmes in more than a dozen countries. For further tips, examples and context, see *Standards for curriculum-based reproductive health and HIV education programs* at: http://www.fhi.org/en/Youth/YouthNet/Publications/otherpubs.htm.

- **Provide access to services and commodities for prevention of reproductive health problems.**

  In addition to information and life skills, SRH education interventions need to be complemented by adolescent-friendly

Box 3: STANDARDS FOR SRH/HIV EDUCATION FOR ADOLESCENTS

Below are standards for developing or adapting a reproductive health or HIV education curriculum for young people in developing countries, based on a comprehensive review of evaluated programmes and field experiences. For tips, examples and context, see *Standards for curriculum-based reproductive health and HIV education programs at:* http://www.fhi.org/en/Youth/YouthNet/Publications/otherpubs.htm.

Development and adaptation

1. Involve professionals, stakeholders, and those with relevant experience in the development process.
2. Conduct assessments of the target group(s)' needs and assets.
3. Use a planning framework that relates health goals, desired behaviour change, and activities.
4. Consider community values and norms in designing activities.
5. Consider availability of resources.
6. Pilot-test curriculum and revise as needed.

Content and approach

1. Incorporate a means to assure a safe environment for participating and learning.
2. Focus on clear health goals in determining curriculum content, approach, and activities.
7. Use activities, messages, and methods that are appropriate to the culture, age, and sexual experience of targeted populations.
8. Address gender issues and sensitivities in both the content and teaching approach.
9. Cover topics in a logical sequence.
10. Present information that is scientifically and medically accurate.

Implementation

1. Make relevant authorities and gatekeepers aware of the programme's content and timetable, keep them informed, and encourage them to support the programme.
2. Establish a process resulting in the selection of appropriate and motivated educators.
3. Provide quality training to educators.
4. Have in place management and supervision needed for